

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

8464

Do not use this space.

1. PLACE OF DEATH

(a) County VernonRegistration District No. 875(b) Township CenterPrimary Registration District No. 6160Registered No. 65(c) City Nevada

(d) Street No. _____ (If death occurred in Hospital or Institution, write its name instead of street and number)

(e) Length of residence in city or town where death occurred

yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.

2. PRINT FULL NAME

(a) Residence, No. Vernon Co Mo St. ☐

(Usual place of abode, if no street address, write county or city)

(If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED

HUSBAND OF (OR) WIFE OF

Delia Cordelia Kelley

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

Jan 23 18597. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
81 0 298. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired Farmer
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____12. BIRTHPLACE (CITY OR TOWN) Maundville
(STATE OR COUNTRY) Missouri13. NAME Thomas Kelley14. BIRTHPLACE (CITY OR TOWN) Unknown
(STATE OR COUNTRY) G15. MAIDEN NAME Rosella Zarnbaugh16. BIRTHPLACE (CITY OR TOWN) Ireland
(STATE OR COUNTRY) I17. INFORMANT (ADDRESS) Mrs. Franklin Kelley
Nevada, Mo.18. BURIAL, CREMATION, OR REMOVAL
Place Moore Cemeter DATE Feb 25 194019. FUNERAL DIRECTOR (NAME) Ferry Funeral Home
(ADDRESS) Nevada Mo20. FILED 2-29 1940 Allen E. Hays
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Feb 22 194022. I HEREBY CERTIFY, That I attended deceased from Jan 15 1940 to Feb 22 1940I last saw him alive on Feb 21 1940. Death is said to have occurred on the date stated above, at 11 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
<u>Chronic Cholelithiasis</u>	<u>2-19-40</u>
<u>Chronic R & R Disease</u>	<u>131</u>
Other contributory causes of importance:	
<u>Ch. R. & R. Disease</u>	<u>6 mo</u>
<u>Ch. Cholelithiasis</u>	<u>3 mo</u>

Name of operation none Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? Yes23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.Manner of injury _____
Nature of injury _____24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) Allen E. Hays _____, M. D.
(Address) Nevada Mo

RECEIVED

Coroner's Office No. 7,

District File Number 3-40-375

Date Filed 3-4-42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by *Personally*

....., Registered Apprentice No.
working under my personal supervision.

Signed *Lloyd R. Winicath*

Licensed Embalmer No. *3867*

P. O. Address *Quincy, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8464

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 875

Primary Registration District No. 6160

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Shropshire
(b) City or town Centerville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: _____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRINT FULL NAME Franklin Egbert Kelley

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Delia Cordelia Kelley 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

8. AGE: Years 81 Months - Days 29 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace _____ (City, town, or county) _____ (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 2/25/40 (b) Allen V. Hays (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 22 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw h. _____ alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: _____ Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature P. B. Wren (M. D. or other) _____

Address Meriden, Conn Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD.

SUPPLEMENTARY

